What do I need to know about the CMS Proposed Rules for EHR Incentive Payments?

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Disclaimer

- Not legal analysis or advice
- Preliminary Analysis based on reading CMS Proposed Rule and analysis by health care policy organizations
- Office of Vermont Health Access (OVHA) and Centers for Medicare and Medicaid (CMS) will publish additional rules and guidelines

Meaningful Use Topics

- Goals and Implementation Stages
- Eligibility for Professionals
- Medicare and Medicaid Incentives
- Requirements to Achieve Meaningful Use
  - Core measurements
  - Specialty Measurements
- Eligibility and Incentives for Hospitals

Why should I care about the HITECH (American Recovery and Reinvestment Act)?

- HITECH goal: use HIT to improve quality of care
  - — created incentive payments for Medicare and Medicaid eligible professionals
    - Up to $44,000 Medicare incentives
    - Up to $63,750 Medicaid incentives
- CMS establish criteria for achieving meaningful use of certified EHR systems
    - Issued Notice of Proposed Rule December 30, 2009
    - Comments due March 15

What are the Meaningful Use Goals? *

1. Electronically capturing health information in a coded format
2. Tracking key clinical conditions and communicating that information for care coordination purposes
3. Implementing clinical decision support tools to facilitate disease and medication management
4. Reporting clinical quality measures and public health information

* States may add requirements to the Medicaid Incentive Program

Which professionals are eligible?

Medicare *

- Doctors of Medicine and Osteopathy
- With some limitations
  - Dentists
  - Podiatrists
  - Optometrists
  - Chiropractors
- 10% higher incentive for "predominantly" practicing in a Health Professional Shortage Area (HPSA)

Medicaid *

- Patient Volume Thresholds
  - Physicians
  - Dentists
  - Certified Nurse Midwives
  - Nurse practitioners
  - Pediatricians
  - Physician Assistants at FQHC/RHC led by PA

* Hospital based professionals are not eligible …… more discussion later

What is qualifying Medicaid patient volume?

Eligible Professionals	Min. 90-day Patient Volume *	Comments
Physicians	30%	Threshold for Eligible Professionals , predominantly practicing in FQHC/RHC, must have a 30% "needy individual" patient volume
Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
PAs at FQHC/RHC	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's hospital	n/a	

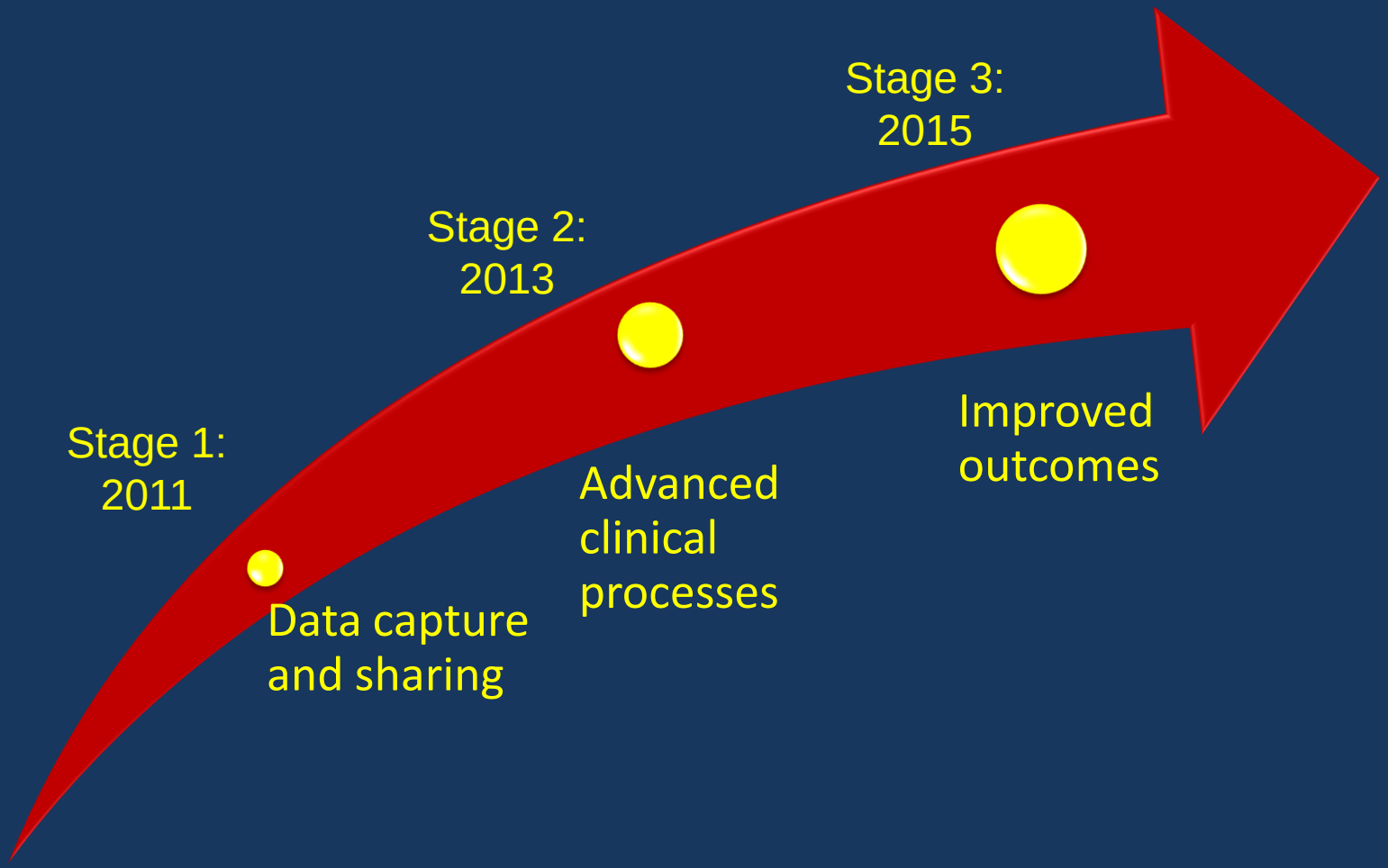
* Starting 2013, a full year of patient volume needs to be met.

Are there limitations for Eligible Professionals?

- EPs can only receive Medicare or Medicaid; not both
- EPs can switch once before 2015
- Individual EPs must meet meaningful use
  - Incentives are not based on a practice meeting meaningful use
- EPs are excluded if they are hospital based
  - "… site of service… without regard to employment/billing arrangement …"
  - Excludes Place of Service (POS) codes 21, 22, 23

more details on "hospital based" at end of presentation

Will all the Meaningful Use requirements start immediately?



How does an Eligible Professional Achieve Meaningful Use?

1. Use certified EHR technology *
   - ONC estimates most currently certified EHRs will qualify
2. Submit clinical quality measures
3. Electronically exchange health information to improve quality of care
   - Vermont HIEN operated by VITL

* Currently EHRs are certified by Certification Commission for Health IT. In the future there will be additional organizations.

How are incentives calculated?

- Medicare
  - Incentive is calculated by multiplying EP's allowable physician fee schedule charges by 75%
    - Includes professional (not technical) components in Part B
- Medicaid
  - Incentives are flat fees that cover "net average allowable" EHR costs multiplied by 85%
  - Less external funds (Stark)
- Medicare and Medicaid incentives are capped
- Medicare Advantage Organizations have different eligibility requirements and incentives

Medicaid: Schedule of Maximum Payments

1st Year for Meaningful Use	Payment Year						
	2011	2012	2013	2014	2015	2016	2017-21
2011 $63,750	Stage 1* $21,250	Stage 1 $8,500	Stage 2 $8,500	Stage 2 $8,500	Stage 3 $8,500	Stage 3 $8,500	
2012 $63,750		Stage 1 $21,250	Stage 1 $8,500	Stage 2 $8,500k	Stage 3 $8,500	Stage 3 $8,500	Stage 3 $8,500
2013 $63,750k			Stage 1 $21,500	Stage 2 $8,500k	Stage 3 $8,500	Stage 3 $8,500	Stage 3 $8.5k*2
2014 $63,750k				Stage 1 $21,500	Stage 3 $8,500	Stage 3 $8,500	Stage 3 $8.5k*3
2015 - 2021 $63,750					Stage 3 $21,500	Stage 3 $8,500	Stage 3 $8.5k*4

* Adopting, implementing, or upgrading EHRs (including staff training and redesigning workflow) qualifies for a payment in 2011 but not subsequent years.

Medicare: Schedule of Maximum Payments

1st Year for Meaningful Use	Payment Year					
	2011	2012	2013	2014	2015	2016
2011 $44k	Stage 1* $18k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3 $2k	
2012 $44k		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	Stage 3 $4k	Stage 3 $2k
2013 $39k			Stage 1 $15k	Stage 2 $12k	Stage 3 $8k	Stage 3 $4k
2014 $24k				Stage 1 $12k	Stage 3 $8k	Stage 3 $4k
2015 Penalties					-1%	-2%

* No Medicare payment similar to Medicaid early adoption option

What are the Stage 1 measures?

1. HIT functional measures (25 measures)
   a. Functional measures relying on capabilities of certified EHRs
   b. Functional measures requiring health information exchange
   c. Security Policy and Procedures
2. Clinical quality measures based on PQRI/NQF *
   a. Core measures (3 measures)
   b. Specialty measures (15 specialties)

*PQRI: Physician Quality Reporting Initiative; NQF: National Quality Forum

What are the core group of quality measures?

1. Preventive Care and Screening
    a. Inquire about Tobacco Use
2. Blood Pressure measurement
3. Drugs to be avoided in elderly
    a. Patients who receive at least one drug to be avoided
    b. Patients who receive at least two different drugs to be avoided

What are the specialties for reporting additional quality measures?

- Cardiology
- Pulmonology
- Endocrinology
- Oncology
- Proceduralist/Surgery
- Primary Care
- Pediatrics
- OB/GYN
- Neurology
- Psychiatry
- Ophthalmology
- Podiatry
- Radiology
- Gastroenterology
- Nephrology

CMS invites comment on whether there are eligible professionals who believe no specialty group will be applicable to them.

How will the quality measures be reported?

- For 2011, attest to EHR use to capture data elements and calculate results
  - For Medicare EPs, attest to accuracy and completeness of numerators and denominators for metrics
- For 2012, requires reporting clinical quality measures through certified EHR for 90 consecutive days
- Starting 2013, requires complete year of quality reporting

Summary of Incentive Programs

Medicare

- No patient thresholds
- No mid-levels
- Incentive capped at $44,000 and calculated as 75% of allowable PFS charges
- HPSA 10% bonus
- Penalties for non-compliance

Medicaid

- Thresholds 30%, some exceptions
- Mid-levels included
- Incentive capped at $63,750 and calculated as a flat fee payment based on 85% of EHR “net allowable costs”
- No penalties

What are my next steps?

- Determine if you qualify for the Medicare or Medicaid incentive program (look at your patient panel profile)
- If you do not already have a certified EHR, establish a plan to acquire a system
- If you already are using a certified EHR, determine what you need to do to meet the meaningful use criteria (Stage I meaningful use checklist on VITL website)
- VITL has been designated by ONC to be a Regional HIT Extension Center. VITL is being funded to provide project management and consulting services to health care providers
- Please contact Larry Gilbert lgilbert@vitl.net for more information

- See next slides for more details:
  - CMS Volume Thresholds
  - HIT Functional Measures (all 25)
  - Hospital Based Professionals
  - Incentives for Eligible Hospitals

Hospital-Based EPs

- A significant limitation on the EP incentive payments is that "hospital-based" EPs are not eligible. Under ARRA, a hospital-based EP is one "who furnishes substantially all of [his or her] services in a hospital setting (whether inpatient or outpatient)" and "through the use of the facilities and equipment, including qualified electronic health records, of the hospital." The determination of whether an EP is hospital-based is to be made "on the basis of the site of service . . . and without regard to any employment or billing arrangement between the eligible professional and any other provider." ARRA leaves CMS with broad discretion to establish criteria regarding what qualifies as furnishing "substantially all" of an EP's services in a "hospital setting" …… (continued on next slide)

- Source: Manatt Health Solutions Analysis of CMS Proposed Rule

Hospital-Based EPs
(continued)

- CMS proposes to define "substantially all" as furnishing at least 90 percent of services in an inpatient or outpatient hospital setting. CMS would make this determination using place of services (POS) codes— specifically, all services paid for under claims with POS codes 21 (inpatient hospital), 22 (outpatient hospital), and 23 (emergency room, hospital) would be considered services furnished in an inpatient or outpatient hospital setting. Services provided in a provider-based outpatient department would count toward the 90 percent threshold.
- CMS notes that, under its proposed definition, 27 percent of all physicians and 12-13 percent of family practitioners would be considered hospital-based. On the other hand, as CMS also observes, this inclusive definition of "substantially all" would also exclude a larger number of EPs from the Medicare payment penalties that begin in 2015.
- Source: Manatt Health Solutions Analysis of CMS Proposed Rule

CMS Volume Threshold

- CMS, with a stated aim of capturing the highest number of Medicaid practitioners potentially eligible for the program, proposes use of the following formula to determine whether EPs or hospitals satisfy volume criterion:
  - Total Medicaid patient encounters in any representative 90-day period in the preceding calendar year
  - Multiplied by 100
  - Result divided by all patient encounters for the same provider over the same 90-day period.
- CMS says that its intent is not to prescribe rigid standards but instead to use a more flexible “plain meaning” test in applying this methodology.
- CMS also permits States to propose alternative approaches.
- Source: Manatt Health Solutions Analysis of CMS Proposed Rule

Are all hospitals eligible?

Medicare *

- Hospitals using inpatient prospective payment system (IPPS)
- Critical Access Hospitals
- Excludes
  - inpatient rehabilitation facilities
  - long term care hospitals

Medicaid *

- Acute Care Hospitals (10%)
- Children's Hospitals (0%)
- Excludes
  - Critical Access Hospitals
  - long term care hospitals (LTCHs)

* Most hospitals may receive both Medicare and Medicaid incentives

Medicaid/Medicare Incentives for EHs [a]

$2 million for based year plus discharge	
Plus: Medicaid/Medicare discharges 1,150 – 23,000 [b]	$200 per discharge
Multiple by Transition factor	1st yr: 1.00 2nd yr : .75 3rd yr: .50 4th yr: .25
Multiple by Medicaid/Medicare share of discharges	? %

(a) Hospitals are eligible for both Medicaid and Medicare incentives.
(b) Discharge limits for yrs 2-4 increased base on 3 yr historic growth rate.

What are the HIT functional measures for EPs?

A. Functional measures relying on capabilities of certified EHRs

1. CPOE used for at least 80% of all orders
2. Maintain updated problem list using ICD-9-CM or SNOMED CT for 80% of unique patients seen by EP
3. Maintain active medication list (80%)*
4. Maintain active medication allergy list (80%)*
5. Record smoking status for patients 13 and older (80%)*
6. Record Demographics (80%) *

* % of unique patients seen by EP

What are the HIT functional measures for EPs? (continued)

7. Record and chart changes in vital signs (80%) *
8. Generate at least one report listing patients by specific condition
9. Send reminders to 50% of patients age 50 and over
10. Provide patients with an electronic copy of their health information (80% within 48 hours) *
11. Provide patients with electronic access to their health information within 96 hours (10%) *

* % of unique patients seen by EP

What are the HIT functional measures for EPs? (continued)

12. Provide clinical summaries for 80% patient requests
13. Perform medication reconciliation 80% of encounters
14. Provide summary care record for each transition of care and referral (80%)*
15. Enable drug-drug, drug-allergy, drug-formulary function
16. Implement 5 clinical decision support rules relevant to clinical quality metrics EP is responsible for

* % of unique patients seen by EP

What are the HIT functional measures for EPs? (continued)

B. Functional measures requiring health information exchange

1. At least 75% of all permissible prescriptions are transmitted electronically using EHR
2. At least 50% of clinical lab tests ordered are incorporated into EHR as structured data
3. Check insurance eligibility electronically (80%)*
4. Submit 80% of claims electronically

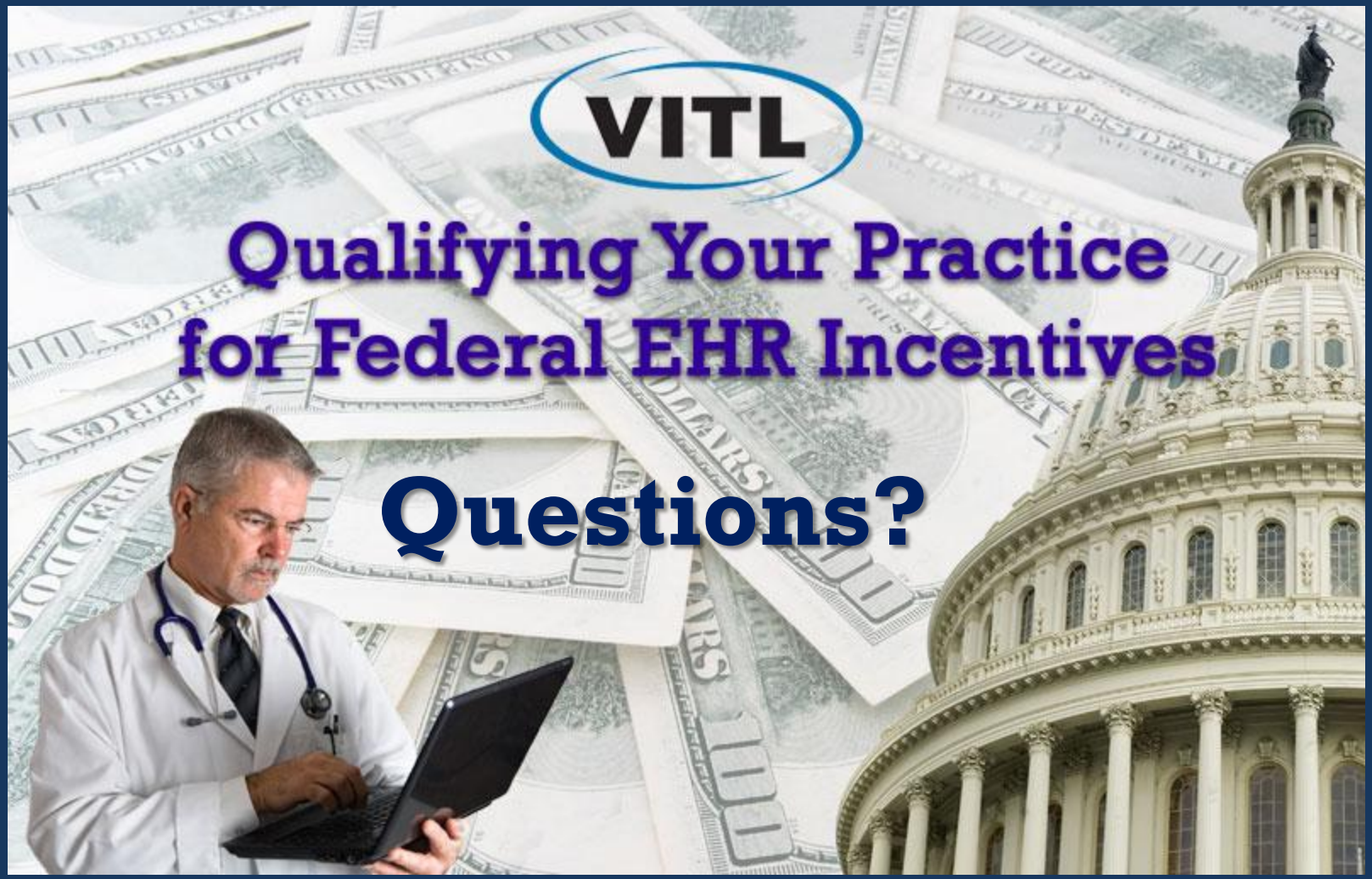
* % of unique patients seen by EP

What are the HIT functional measures for EPs? (continued)

Perform at least one test of EHR's capacity to:

5. submit electronic data to immunization registries
6. provide electronic syndromic surveillance data to public health agencies
7. provide electronic submission of reportable lab results to public health agencies
8. Electronically exchange key clinical information

C. Security Measure: Conduct or review a HIPAA security risk analysis and implement security updates as necessary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Questions?